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# URBAN LEGEND: DISPELLING THE MYTH THAT RURAL HOSPITALS REQUIRE INCREASED FEDERAL FUNDING AT THE EXPENSE OF URBAN HOSPITALS

*David Moyse*

Due to a variety of social, economic, and infrastructural differences, rural and urban areas are often at odds on policy issues. For many decades, the federal government has dealt with the issue of how to create policies that treat rural and urban areas fairly and equitably.<sup>1</sup> This has been particularly true in the health care industry,<sup>2</sup> where rural hospitals have traditionally cited difficulties with inadequate facilities,<sup>3</sup> a shortage of qualified physicians,<sup>3</sup> and insufficient federal funding.<sup>4</sup> Some health care industry insiders point to the state of rural hospitals in the late 1980's when the "rural 'problem' turned into a crisis, as operating margins for rural hospitals plummeted and rural facilities closed in disproportionately large numbers."<sup>5</sup> However, urban hospitals have also faced severe financial pressures and difficulties. Proponents of hospitals in urban areas argue that the reaction to help rural hospitals has gone too far and has neglected health systems in

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1. See Debra Lyn Basset, *Ruralism*, 88 IALR 273, 276-80, (2003) (discussing biases against rural areas and ineffective political policies aimed at correcting inequalities).

2. W. Eugene Basanta, *Rural Health Care Now and Tomorrow: A Symposium Introduction and Overview*, 23 J. LEGAL MED. 37, 37 (2002).

3. David Brown, *Recruiters Offer Doctors A Small-Town 'Option'; Aggressive Approach Taken Amid Shortages*, WASH. POST, Oct. 6, 1991, at A03 ("In 1988, for example, 111 counties across the country had not one doctor. In counties with less than 10,000 population, there were roughly half as many primary care doctors per capita as in urban and suburban areas.").

4. Joseph A. Kuchler, *Washington Takes Steps to Help Rural Hospitals*, HEALTHCARE FINANCIAL MANAGEMENT, Apr. 1, 1990, at 76.

5. *Id.*

major urban areas.<sup>6</sup> Recent Bush Administration changes to the Medicare system<sup>7</sup> have renewed the debate over federal funding for rural and urban hospitals.<sup>8</sup>

On December 8th, 2003, President Bush signed the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA") into law.<sup>9</sup> Several sources have cited the MMA as the "largest expansion of the Medicare program since it was created in 1965."<sup>10</sup> Proponents touted the MMA for its enhanced prescription drug benefit programs, but it also contained provisions directed towards helping hospitals in some rural areas.<sup>11</sup> Relatively unnoticed amidst the changes was a redefinition of the boundaries used for calculating Medicare funding that took effect on October 1st, 2004.<sup>12</sup> The Office of Management and Budget ("OMB") changed its traditional definition of metropolitan areas to include more outlying suburbs and surrounding counties.<sup>13</sup> The Centers for Medicare and Medicaid Services ("CMS") adopted these newly defined areas for the purposes of calculating wage indexes for geographical areas and determining the amount of Medicare funding that hospitals receive.<sup>14</sup> As a result, a number of hospitals in major urban areas will receive significantly less funding than in prior years, and the newly included hospitals will receive an

6. NAT'L ASS'N OF URBAN HOSP., THE OPERATING MARGINS OF URBAN SAFETY-NET HOSPITALS AND THE PROJECTED IMPACT OF REDUCTIONS OF MEDICARE DSH ON THOSE OPERATING MARGINS, i (2003), available at [http://www.nauh.org/docs/p14/NAUH\\_2003\\_UHD.pdf](http://www.nauh.org/docs/p14/NAUH_2003_UHD.pdf) (citing studies that urban hospitals have lower operating margins than rural hospitals, and that Medicare DSH payments to urban hospitals are inadequate).

7. Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-279, 117 Stat. 2066.

8. Marc Santora, *New York Hospitals to Sue Over Medicare Rule Change*, N.Y. TIMES, Aug. 25, 2004, at B02.

9. Press Release, Office of Press Secretary, President Signs Medicare Legislation, (Dec. 8, 2003), available at <http://www.whitehouse.gov/news/releases/2003/12/20031208-2.html>.

10. Lisa Barrett Mann, *Finding the Me in Medicare*, WASH. POST, Feb. 24, 2004, at F01; see also Press Release, Centers for Medicare and Medicaid Services, CMS Increases Payments to Rural and Small Urban Hospitals (Mar. 31, 2004) (stating that the recent Medicare changes represent the most comprehensive changes to the program since its creation in 1965); see also Scott Lindlaw, Associate Press, *Bush Signs Historic Medicare Changes*, IND. STUDENT DAILY, Dec. 9, 2003, available at <http://www.idnews.com/story.php?id=20287> (last visited Sept. 23, 2005) (calling the new Medicare law the most far-reaching changes since the inception of the program).

11. See Lindlaw, *supra* note 10.

12. Santora, *supra* note 8, at B02.

13. *Id.*

14. 42 C.F.R. § 412.64 (2004).

increase in funding.<sup>15</sup> New York City projects a \$132 million loss in funding over the next two years and an estimated \$812 million over the next ten years.<sup>16</sup> In response to the changes, a group of twenty-eight New York City hospitals have filed suit against the Department of Health and Human Services (“HHS”), its secretary Tommy G. Thompson, and CMS.<sup>17</sup>

This comment will challenge the traditional notion that rural hospitals are struggling in comparison to urban hospitals. While rural hospitals did face great financial difficulties in the 1980’s and early 1990’s, these problems were addressed by Congress and are no longer as severe.<sup>18</sup> On the contrary, it is urban hospitals that now face a greater threat of financial insolvency. The changes in Medicare funding enacted by the Bush administration worsen these financial problems.<sup>19</sup> Further, this comment will argue that CMS adopted the new geographical boundaries in an arbitrary and capricious manner, without consideration for the magnitude of the financial impact that hospitals in major urban areas would experience.

Part I of this comment examines the notion that rural hospitals suffer in comparison to urban hospitals, and analyzes the arguments for difficulties

15. *See id.*

16. Plaintiff’s Complaint at ¶28, *Bellevue Hospital Center v. Thompson*, No. 04 Civ. 08639 (S.D.N.Y. filed Nov. 1, 2004); Santora, *supra* note 8, at B02 (citing the Greater New York Hospital Association’s estimate that the changes would cost \$930 million over the next 10 years).

17. *See* Plaintiffs’ Complaint, *Bellevue* (No. 04 Civ. 08639); *see also* Santora, *supra* note 8, at B02.

18. *See* Basanta, *supra* note 2, at 37 (stating that “health care in rural America seems to be in a constant state of stress”); *but see* Amy Goldstein, *Hill Supports Medicare Boost to Rural Areas*, WASH. POST, Oct. 20, 2003, at A01 (citing a 2001 study conducted by the Medicare Payment Advisory Commission that found relatively little difference between the percentage of people who received care in rural hospitals versus urban hospitals).

19. *See* NAT’L ASS’N OF URBAN HOSP., *THE OPERATING MARGINS OF URBAN SAFETY-NET HOSPITALS AND THE PROJECTED IMPACT OF REDUCTIONS OF MEDICARE DSH ON THOSE OPERATING MARGINS*, *supra* note 6 at 24-25 (concluding that large urban hospitals are in much worse financial condition than non-urban hospitals). In addition, “large urban safety-net hospitals that provide more than 15 percent of their services to Medicaid recipients are in especially precarious financial condition.” *Id.* at 24. The study goes on to conclude that reducing federal spending on Medicare DSH could cause considerable damage to large urban hospitals. *Id.* at 25. *See also* Deloitte, *Decentralization, Consistency, and Concentration on Delivery and Quality Account for ProMedica’s Rapid Rise to Fourth Most Integrated U.S. Health System*, *CEO Says*, HEALTH CARE REVIEW July-Aug. 2004, at 5, available at [http://www.deloitte.com/dtt/cda/doc/content/us\\_healthcare\\_hcr\\_0904%281%29.pdf](http://www.deloitte.com/dtt/cda/doc/content/us_healthcare_hcr_0904%281%29.pdf) (statement of Alan W. Brass, CEO and President of ProMedica Health System) (“Our rural hospitals are holding their own right now. It’s our urban centers that are getting hit the hardest at this time.”).

faced by rural health systems.<sup>20</sup> Part II discusses the difficulties faced by urban hospitals<sup>21</sup> and also notes newly emerging problems unique to them.<sup>22</sup> Part III examines the legislative efforts to help rural areas, most notably the Office of Management and Budget's administrative changes and redefinition of the boundaries used for Medicare funding.<sup>23</sup> Part IV argues that the changes in funding areas are crippling to major urban areas such as New York City.<sup>24</sup> Part IV further argues that the changes were adopted in an arbitrary manner without examining the effect on major urban areas.<sup>25</sup> Finally, this comment also looks at the areas that benefit from the Bush administration's changes, while examining possible political motivations.

## I. RURAL HOSPITAL PERSPECTIVE

### A. Claims of a Historical Bias Against Rural Areas

Rural areas have long claimed that their residents face a "decidedly second-class status under the law, under government benefits and policies, and, indeed, under all things that truly matter."<sup>26</sup> Critics argue that a lack of organized lobbying efforts from rural regions has resulted in government policies that disproportionately favor urban areas and residents.<sup>27</sup> They claim that because rural areas are sparsely populated and dispersed, it is difficult to "build a national constituency for rural issues or a national rural policy."<sup>28</sup> The lack of an organized or powerful constituency among rural

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20. See discussion *infra* Parts I.A, I.B (discussing the historical basis of the view that rural areas are underrepresented in the federal government and arguments for increased funding for rural hospitals).

21. See discussion *infra* Part II.A (examining arguments that urban health systems have traditionally required greater funding than rural health systems).

22. See discussion *infra* Part II.B (discussing the new financial pressures that urban hospitals face in preparing for large scale terrorist attacks).

23. See discussion *infra* Parts III.A, III.B, III.C (discussing the recently enacted MMA and the changes in funding level calculation).

24. See discussion *infra* Part IV.A (examining the financial impact of HHS's adoption of new geographical boundaries for calculating Medicare reimbursements).

25. See discussion *infra* Part IV.B (arguing that the decision to adopt the new geographical definitions was made arbitrarily, and without consideration of the full economic consequences).

26. Basset, *supra* note 1, at 276.

27. JANET M. FITCHEN, *ENDANGERED SPACES, ENDURING PLACES: CHANGE, IDENTITY, AND SURVIVAL IN RURAL AMERICA* 266 (Westview Press 1991).

28. *Id.* at 266-67.

areas also makes it “hard to defend federal spending for rural programs.”<sup>29</sup> In other words, the lack of a dense voting core yields little political advantage toward helping specific rural areas.

Ultimately, these critics argue that the “federal government has generally failed to perceive rural problems in their broader sense, beyond agriculture and beyond economic problems.”<sup>30</sup> In particular, many critics point to the severe financial and labor problems faced by rural hospitals in the 1980’s and 1990’s.<sup>31</sup> Although hospitals in both rural and urban areas faced financial pressures at this time, the hospitals in rural areas were closing at disproportionately higher rates relative to their urban counterparts.<sup>32</sup> Advocates of increased federal funding for rural hospitals argue that this discrepancy still exists today.<sup>33</sup>

### *B. Difficulties Faced by Rural Hospitals*

In terms of Medicare funding, advocates for rural hospitals offer a variety of arguments for why the federal government should fund them equally to urban hospitals.<sup>34</sup> First, proponents argue that they lack the high-volume of patients, as compared with urban hospitals, which helps offset overhead costs.<sup>35</sup> Regardless of the number of patients in a facility, there are minimum requirements in terms of labor and equipment availability.<sup>36</sup> Even if no one shows up, the hospital must be properly staffed and equipped to handle emergencies.<sup>37</sup> Larger amounts of patients give urban hospitals better economies of scale and help diffuse costs for new equipment and day-

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29. *Id.*

30. *Id.*

31. See Brown, *supra* note 3 at A03; see also Julie Morris, *Rural USA Fights to Save Its Hospitals*, USA TODAY, Dec. 19, 1988, at A01 (citing a University of Illinois study that predicted that approximately 600 of the nation’s 2,700 rural hospitals could be out of business before 1990).

32. See Kuchler, *supra* note 4, at 76.

33. Associated Press, *Rural Hospitals Hang Hopes on Medicare Changes*, COLUMBIA DAILY TRIBUNE, Aug. 30, 2003, available at <http://www.showmenews.com/2003/aug/20030830news012.asp>.

34. *Id.*

35. *Id.*

36. Senator Michael B. Enzi, Statement on Medicare Conference Agreement, (Nov. 24, 2003), <http://enzi.senate.gov/medsta.htm>.

37. *Id.* Sen. Enzi stated, “Most rural hospitals also have a low patient volume compared to their urban counterparts, and this contributes to a higher cost of rural hospital care. There is a certain amount of staff and everything that has to be on hand ready for patients if they show up.” *Id.*

to-day operations.<sup>38</sup> Rural hospitals unable to benefit from these efficiencies often suffer from shortages in updated equipment and qualified staff.<sup>39</sup>

Secondly, rural hospitals point to increased costs resulting from shortages of registered nurses and other hospital personnel.<sup>40</sup> Rural hospitals argue they are forced to raise compensation levels in order to compete with the higher salaries offered by facilities in urban areas.<sup>41</sup> The argument is that these hospitals must hire from the same labor pools as urban hospitals and therefore have to pay disproportionately high salaries in order to compete for staff.<sup>42</sup>

Another argument raised by rural hospitals is that their equipment and procedural costs are equal to those of urban hospitals.<sup>43</sup> Despite the equal cost of purchasing and operating the equipment, Medicare reimburses the rural hospitals at a lower rate than urban hospitals performing the same procedures.<sup>44</sup> Senator Byron L. Dorgan (D-N.D.) argues that because of the inequities in Medicare reimbursement, rural hospitals “have to reduce services, have greater difficulty recruiting staff, are less able to make capital improvements, and struggle to give their patients access to the latest innovations in medical care.”<sup>45</sup> Further, Senator Dorgan argues that reduced reimbursement rates are unfair considering that rural citizens pay the same Medicare payroll tax rates as urban citizens.<sup>46</sup>

Finally, proponents of increased Medicare funding for rural hospitals point to demographic and social factors.<sup>47</sup> Specifically, statistics indicate that a disproportionately high number of elderly people reside in rural areas.<sup>48</sup> The argument is that younger people have migrated from rural areas

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38. Associated Press, *supra* note 33.

39. Bassett, *supra* note 1, at 318.

40. Press Release, Am. Hosp. Ass’n, Am. Hosp. in Midst of Workforce Shortage (June 5, 2001), available at [http://www.aha.org/aha/hospitalconnect/search/pressrelease.jsp?dcrpath=AHA/Press\\_Release/data/AHAPRESSRELEASES-0702x81&domain=AHA](http://www.aha.org/aha/hospitalconnect/search/pressrelease.jsp?dcrpath=AHA/Press_Release/data/AHAPRESSRELEASES-0702x81&domain=AHA) (last visited Oct. 30, 2004).

41. Associated Press, *supra* note 33.

42. See, e.g., Chris Lundy, *Health Benefits: Medicare Changes Benefit Local Hospitals*, OCEAN COUNTY OBSERVER, Aug. 5, 2004, at A3; see also Associated Press, *supra* note 33; see also Enzi, *supra* note 36.

43. See, e.g., Press Release, Senator Byron L. Dorgan, Rural Health Care Fairness and Medicare Equity Act, available at <http://dorgan.senate.gov/legislation/medicareequity.cfm>.

44. *Id.*

45. *Id.*

46. *Id.*

47. Associated Press, *supra* note 33.

48. Mary Wakefield, *Patient Safety and Medical Errors: Implications for Rural Health Care*, 23 J. LEGAL MED. 43, 53 (2002) (arguing that “[g]iven the high proportion

to urban areas in search of higher-paying jobs.<sup>49</sup> As a result, rural hospitals are “increasingly reliant on Medicare patients.”<sup>50</sup> Statistics show that in 2000, over 50% of rural hospitals reported that the majority of their gross revenues came from Medicare payments.<sup>51</sup> In contrast, “only 31% of urban hospitals” reported the same reliance on Medicare payments.<sup>52</sup> Hospital directors in rural areas claim that dependence on Medicare for revenue makes them more vulnerable to changes in policy.<sup>53</sup>

Despite the arguments advanced describing the difficulties of rural hospitals, many industry experts feel that rural hospitals have significantly improved from the financially difficult times of the 1980’s and early 1990’s.<sup>54</sup> These experts argue that under the current market conditions, hospitals in urban areas are less financially stable than their rural counterparts.<sup>55</sup> The following section will analyze the arguments for providing increased funding to urban hospitals.

## II. URBAN HOSPITAL PERSPECTIVE

### *A. Problems Faced by Urban Hospitals*

For the greater part of the last 100 years, the American landscape has become increasingly urbanized.<sup>56</sup> In fact, a majority of the American public

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of elderly [people] residing in rural areas, Medicare has a compelling interest in ensuring that these beneficiaries have access to high-quality, safe care”).

49. See Associated Press, *supra* note 33.

50. *Id.*

51. *Id.* (“more than 50 percent of the nation’s 2,200 rural hospitals reported that Medicare made up more than half of their gross revenue.”).

52. *Id.* (quoting administrator at Kossuth Regional stating “we are dependent on Medicare, and that makes us vulnerable.”).

53. *Id.*

54. See Deloitte, *supra* note 19, at 5.

55. *Id.* (quoting CEO of ProMedica Alan Brass stating “our rural hospitals are holding their own right now. It’s our urban centers that are getting hit the hardest at this time.”).

56. STEPHEN S. BIRDSALL & JOHN FLORIN, DEP’T. OF STATE, AN OUTLINE OF AMERICAN GEOGRAPHY: REGIONAL LANDSCAPES OF THE UNITED STATES Chap. 1 (1998), available at <http://usinfo.state.gov/products/pubs/geography/geog01.htm> (“The pattern of continuing and often rapid urban growth in the United States during the last 100 years, coupled with the increasing mobility of the urban population, has stimulated a great sprawling pattern of urbanization.”).



now lives in large metropolitan areas.<sup>57</sup> These population shifts have resulted in densely populated areas and high levels of urban poverty.<sup>58</sup> The following is an overview of why urban hospitals now face greater problems than rural hospitals.

In terms of health care, urban hospitals face many of the same general problems as rural hospitals. Labor shortages and rising costs of updated equipment are problems universal to hospitals, regardless of location.<sup>59</sup> In a broader perspective, the health of urban hospitals across the country is crucial because they represent “the core safety net for low-income, uninsured individuals.”<sup>60</sup> The greater numbers of low-income, uninsured individuals living in urban areas strain hospitals because the individuals are unable to pay for rendered services.<sup>61</sup> As a result, urban hospitals must contend with lower payment rates from patients than their suburban counterparts, hindering their ability to offset operating expenses.<sup>62</sup>

Urban hospitals face much higher operating expenses than rural hospitals.<sup>63</sup> Higher labor costs play a role in these higher operating expenses.<sup>64</sup> Urban areas have higher standard of living expenses, so

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57. *Id.* at Ch. 1 (citing 1990 Census figures, which state that approximately 70% of Americans live in urban areas and 40% live in areas with populations greater than 1 million people).

58. *See id.* at Ch. 1 (citing 1990 Census figures, which state that 40% of Americans live in areas with populations greater than 1 million people.)

59. *See* Press Release, Am. Hosp. Ass’n, *supra* note 40 (citing AHA survey results from more than 700 hospitals).

60. DEBRA A. DRAPER, ET AL., CENTER FOR STUDYING HEALTH SYSTEM CHANGE, COMMUNITY REPORT: URBAN HOSPITALS’ FISCAL HEALTH REMAINS CRITICAL (2001), available at <http://www.hschange.org/CONTENT/359/#jump1>.

61. *See id.*

62. *See id.*; *see also* NAT’L ASS’N OF URBAN HOSP., THE FINANCIAL CONDITION OF URBAN HOSPITALS (2002), available at <http://www.nauh.org/docs/p14/Condition%20of%20Urban%20Hosp.pdf>. In a comparison of every commonly used measure of financial health, urban hospitals fared worse than non-urban hospitals. *Id.* at 11. Additionally, “[u]rban hospitals that treat large numbers of low-income patients fare the worst.” *Id.* *See also* NAT’L ASS’N OF URBAN HOSP., THE OPERATING MARGINS OF URBAN SAFETY-NET HOSPITALS AND THE PROJECTED IMPACT OF REDUCTIONS OF MEDICARE DSH ON THOSE OPERATING MARGINS, *supra* note 6, at 1-2 (describing the importance of Medicare DSH funding to urban hospitals with especially large portions of low-income patients, and stating that the growing reluctance of government and private groups to pay for poor and uninsured patients has put a financial strain on urban hospitals).

63. *See* Parkview Medical Assoc., L.P. v. Shalala, 158 F.3d 146, 147 (D.C. Cir. 1998) (“Because hospital costs tend to be higher in urban areas than in rural, the Secretary’s reimbursement rates vary with a hospital’s geographic area.”).

64. *See* Santora, *supra* note 8, at B02.

employers must pay higher wages in order to attract qualified employees.<sup>65</sup> For example, hospitals in New York City pay wages approximately 36% above the national average for healthcare workers.<sup>66</sup> In contrast, rural hospitals are more likely to pay wages below the national average. The increased labor costs for major urban hospitals pose one of the most serious problems they face in providing health services. As a result, urban hospital administrators and city officials have long relied on Medicare wage adjustments to offset increased labor costs.<sup>67</sup>

Labor costs are not the only factor increasing the operating expenses for hospitals in large metropolitan areas.<sup>68</sup> Malpractice premiums and commercial real estate prices are significantly higher in urban areas.<sup>69</sup> The high population density relative to rural areas logically concludes that urban hospitals require more beds and larger facilities than rural hospitals. This only compounds the problem of paying more money per square foot of real estate. Further, industry analysts note that “urban hospitals also tend to have higher hospitalization rates and longer hospital stays, and also offer a wider variety of services.”<sup>70</sup> Offering a wider variety of services requires hospitals to keep more equipment on hand and possibly have a specialized labor force.

Urban hospitals argue that they face higher rates of serious and substantial health problems than rural hospitals.<sup>71</sup> Two of the most serious and costly health problems today are obesity and smoking, which affect all segments of the health care industry.<sup>72</sup> Yet, urban hospitals also face higher rates of other costly health issues like alcoholism, HIV, and treatment needed as a result of gun violence.<sup>73</sup>

### *B. New Threats Facing Urban Areas*

In addition to traditional problems associated with urban areas, unique burdens have emerged over the past five years. Urban hospitals must now prepare for terrorist attacks.<sup>74</sup> Densely populated metropolitan areas such as

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65. *See id.*

66. *See id.*

67. *See id.*

68. Associated Press, *supra* note 33.

69. *See id.*

70. *Id.*

71. Thomas R. McLean & Edward P. Richards, *Health Care's "Thirty Years War": The Origins and Dissolution of Managed Care*, 60 N.Y.U. ANN. SURV. AM. L. 283, 294 (2004).

72. *See id.*

73. *See id.*

74. Santora, *supra* note 8, at B02.

New York City, Washington, D.C., and Chicago are vulnerable to biological or chemical weapon attacks.<sup>75</sup> As a result, hospitals must spend more money training staff, stocking antidotes, and formulating large-scale emergency response plans.<sup>76</sup>

Further, terrorist threats spurred urban hospitals to buy new equipment and facilities specific to anti-terrorism needs that do not serve any other practical functions.<sup>77</sup> In a report to Congress, the U.S. General Accounting Office ("GAO") noted that "bioterrorism preparedness is expensive and [hospital officials] are reluctant to create capacity that is not needed on a routine basis and may never be needed at a particular facility."<sup>78</sup> Implementation of costly anti-terrorism measures exemplifies the changing landscape of issues facing urban hospitals.<sup>79</sup> Relying on these factors, the Centers for Medicaid and Medicare Services ("CMS") decided that urban hospitals need more money than rural hospitals.<sup>80</sup>

The debate between rural and urban hospital systems rests on a variety of issues, including: lack of rural political clout, disproportionate treatment costs, different patient populations, labor and location expenses, and emergency response planning. Proponents of increased funding for rural hospitals make valid points, but they ignore the changing problems faced by major urban areas. Indeed problems in cities have worsened because attention and resources were spent on rural problems during the 1980s and 1990s. With that in mind, changes to the MMA and to funding districts merit closer scrutiny.

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75. See generally OFFICE OF CIVIL RIGHTS EVALUATION FOR THE INFO. OF THE COMM'RS, COMM'N ON CIVIL RIGHTS, BIOTERRORISM AND HEALTHCARE DISPARITIES (2002), available at <http://www.usccr.gov/pubs/biotbrf/paper.htm> (last visited Oct. 30, 2004) (discussing the preparations made by Federal and State governments to prepare for the possibility of biological or chemical weapon attacks in the United States).

76. *Id.*; see also Santora, *supra* note 8, at B02.

77. See Santora, *supra* note 8, at B02 (stating that urban hospitals are facing "new expenses for equipment and training to deal with an unconventional terrorist attack"). See also U.S. GEN. ACCOUNTING OFFICE, GAO-03-924, HOSPITAL PREPAREDNESS: MOST URBAN HOSPITALS HAVE EMERGENCY PLANS BUT LACK CERTAIN CAPACITIES FOR BIOTERRORISM RESPONSE 2-4 (2003) (concluding that although urban hospitals have taken steps to prepare for bioterrorism response, they lack the medical equipment to handle the increase of patients that a bioterrorism incident would cause).

78. See U.S. GEN. ACCOUNTING OFFICE, *supra* note 77 at 15.

79. *Id.*

80. Associated Press, *supra* note 33.

### III. CHANGES TO MEDICARE AND REDEFINING "URBAN AREAS"

#### *A. Medicare Changes Benefiting Rural Hospitals*

President Bush signed the MMA into law on December 8, 2003 and gave the Medicare system its most comprehensive restructuring since its 1965 inception.<sup>81</sup> Although most of the focus has been upon the Act's prescription drug benefits,<sup>82</sup> the MMA also included significant funding for rural hospital systems.<sup>83</sup> Specifically, the MMA significantly reduced the gap in Medicare reimbursement rates between urban and rural hospitals.<sup>84</sup>

Under the previous Medicare system, a complex formula was used to determine reimbursement rates.<sup>85</sup> Hospitals in large metropolitan areas, such as San Francisco and New York City, would receive an average of 1.6% more reimbursement than hospitals performing the same procedures in Iowa or Kansas.<sup>86</sup> In addition, a separate formula accounted for average cost indexes, wage differences, and malpractice premiums.<sup>87</sup> This formula further adjusted the size of Medicare payments to account for regional cost differences.<sup>88</sup> The entire purpose and effect of these adjustments was to account for the economic disparities urban hospitals faced in terms of higher labor costs, higher real estate costs, and other operating expenses. The MMA created several new formulas aimed at helping rural hospitals to recover more Medicare costs.<sup>89</sup>

According to CMS projections, the new Medicare law will result in a nearly \$12 billion increase in funds to rural hospitals and urban hospitals in

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81. See Mann, *supra* note 10; see also Lindlaw, *supra* note 10.

82. Medicare Program; Medicare Prescription Drug Benefit, 42 C.F.R. §§ 403, 411, 417, 423, (2004).

83. See Patrick Howington, *Medicare Changes to Help Hospitals*, THE COURIER-JOURNAL, Feb. 1, 2004, at E01 ("The centerpiece of the Medicare reform law was a new prescription-drug benefit for seniors, but the law also beefed up reimbursements for many health-care providers, such as physicians and hospitals."); see also Bevin Milavsky, *Hospitals to Receive Higher Reimbursements*, THE DAILY ITEM, Nov. 26, 2003, available at <http://www.dailyitem.com/archive/2003/1126/local/stories/05locoal.htm>.

84. See Associated Press, *supra* note 33.

85. See *id.*

86. *Id.*

87. See *id.*

88. See *id.* (explaining that under the old Medicare system, Medicare would pay, "a hospital in Bismarck, N.D., \$3,988 for a heart failure procedure. For the same procedure, a hospital in New York is paid \$6,460, according to Rep. Earl Pomeroy, D-N.D.").

89. Jim Hook, *Medicare Changes to Have 'Positive Impact'*, THE PUBLIC OPINION, Jan. 13, 2004, at A01.

cities or metro areas with a population of less than one million people.<sup>90</sup> Under the new law, hospitals that have fewer than 100 beds and serve a disproportionate percentage of low-income Medicare patients will also receive an increase in their disproportionate share hospital (“DSH”)<sup>91</sup> payments.<sup>92</sup> DSH payments are made by the federal government to compensate hospitals for the large number of low-income patients who require serious, expensive medical attention, but have no private insurance.<sup>93</sup> Although urban hospitals must handle a disproportionately large number of uninsured patients, the additional DSH payments are only given to qualified hospitals with fewer than 100 beds.<sup>94</sup> In fact, the MMA more than doubled the previous reimbursement caps for DSH payments, increasing them from 5.25% under the old system to 12% under the new system.<sup>95</sup> These funding increases to rural hospitals were due in large part to the lobbying efforts of Senator Charles E. Grassley (R-Iowa) and Senator Max Baucus (D-Mont.), both representatives of states that have historically received lower Medicare payments.<sup>96</sup>

Despite the support of Congress, many industry analysts felt that the increases in reimbursements for rural hospitals were unnecessary.<sup>97</sup> Paul B. Ginsburg, president of the Center for Studying Health System Change, stated that “[m]aybe there is a political dynamic, as opposed to a true problem.”<sup>98</sup> The appearance given by these analysts is that the shift in funding and resources to rural hospitals had more to do with political strategies than with sound financial decision making.<sup>99</sup> In addition, two former HHS administrators testified before Congress that statistics suggesting that rural hospitals were suffering compared to urban hospitals were “meaningless” and ignored crucial facts.<sup>100</sup> The former HHS administrators indicated to Congress that the allocation of money would be better spent if directed more towards helping hospitals in major metropolitan

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90. Press Release, Centers for Medicare and Medicaid Services, *supra* note 10.

91. CRAIG CAPLAN, AARP, FYI: MEDICARE’S DISPROPORTIONATE SHARE HOSPITAL PAYMENTS (1998), available at <http://www.aarp.org/research/medicare/financing/aresearch-import-694-FYI.html>.

92. *Id.*; see also Press Release, Centers for Medicare & Medicaid Services, *supra* note 10 (stating that rural, and urban, hospitals with fewer than 100 beds will receive an increase in DSH payments for discharges beginning on April 1, 2004).

93. See CAPLAN, *supra* note 91.

94. See Press Release, Centers for Medicare & Medicaid Services, *supra* note 10.

95. See *id.*

96. Goldstein, *supra* note 18, at A01.

97. *Id.*

98. *Id.*

99. See *id.*

100. *Id.*

areas. Additionally, the AARP reported that none of its affiliates in eight rural states had reported significant numbers of complaints from members who were unable to find care.<sup>101</sup>

Although the need for the increased benefits to rural hospitals is debated by some Medicare officials and health care experts,<sup>102</sup> MMA was not seen to be damaging to urban hospitals.<sup>103</sup> This is because the benefits to rural hospitals were in the form of new spending measures aimed at closing the reimbursement gap, rather than spending cuts to urban hospitals.<sup>104</sup> However, on May 18, 2004, CMS issued a proposed rule to change Medicare payments for the fiscal year 2005.<sup>105</sup> The proposed rule adopts newly defined geographic areas for calculating average wages, resulting in a dramatic funding loss for urban hospitals.<sup>106</sup>

### *B. Metropolitan Statistical Areas ("MSAs")*

The federal government has used Metropolitan Statistical Areas ("MSAs") for the last fifty years to provide uniform definitions for statistical areas.<sup>107</sup> The official definition of an MSA is a statistical area containing "at least one urbanized area that has a population of at least 50,000."<sup>108</sup> In terms of construction, a MSA "comprises the central county or counties containing the core, plus adjacent outlying counties having a high degree of social and economic integration with the central county as measured through commuting."<sup>109</sup> The general concept of an MSA is a statistical area "containing a recognized population nucleus and adjacent communities that have a high degree of integration with that nucleus."<sup>110</sup> More clearly, the point is to isolate areas of a common population and include surrounding areas which share common characteristics, use the same roads, draw from the same labor pools, and so forth.

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101. *Id.*

102. *See* Associated Press, *supra* note 33.

103. *See generally* Howington, *supra* note 83, at E01.

104. *Id.*

105. Rule for Fiscal Year 2005 PPS Payments, 69 Fed. Reg. 28,196 (proposed May 18, 2004).

106. 42 C.F.R. § 412.64 (2004); *see also* Santora, *supra* note 8 at B02.

107. *See* Standards for Defining Metropolitan and Micropolitan Statistical Areas, 65 Fed. Reg. 82,228 (Dec. 27, 2000).

108. *Id.* at 82,238.

109. *Id.*

110. *Id.* at 82,228.

At their creation, MSAs gave federal agencies a means to more accurately compare statistics for a given geographic area.<sup>111</sup> The underlying purpose is to help policy makers better evaluate the statistical impacts of policies on rural and urban areas.<sup>112</sup> However, the OMB expressly advises against federal and state government agencies use of the MSA definitions to develop and implement programs without first performing a full evaluation of the real effect of the definitions.<sup>113</sup> This is because even though the MSAs are designed to share common characteristics around the same population nucleus, the MSAs “may not accurately address issues or problems faced by local populations, organizations, institutions, or governmental units.”<sup>114</sup>

For instance, an outlying county may be included in an MSA because many of its residents commute to work in a nearby metropolitan area.<sup>115</sup> However, including the outlying county in the MSA due to a commuting pattern may obfuscate the need to reduce the numbers of commuters.<sup>116</sup> In the words of the OMB, “it may also indicate a need to provide programs that would strengthen the county’s rural economy so that workers are not compelled to leave the county in search of jobs.”<sup>117</sup> In other words, the common market of workers shows that the outlying county has characteristics of the urban center, but workers may only be leaving for the major urban area because the county has been so neglected that not enough meaningful jobs are being created.<sup>118</sup> Due to reasons such as this, the OMB explicitly advises agencies to look and evaluate the facts of their situations independent of the MSAs.<sup>119</sup> The agencies should evaluate the real impact of using the MSAs for funding purposes before making serious adjustments to accommodate the definitions used by the OMB.<sup>120</sup>

### C. Redefining “Urban” Area

Relatively unnoticed amidst the many changes of the new Medicare policy was an announcement that Medicare payments would be adjusted to new

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111. *See id.*

112. *See id.*

113. *See id.* at 82,229.

114. *Id.* at 82,228-29.

115. *See id.* at 82,229.

116. *See id.*

117. *Id.*

118. *See id.*

119. *See id.* at 82,228.

120. *See id.*

geographical boundaries.<sup>121</sup> The previous reimbursement system used boundaries based upon the 1990 census and the Office of Management and Budget's ("OMB") definition of urban area.<sup>122</sup> Following the 2000 census, OMB substantially changed their definition of what constitutes an urban area.<sup>123</sup> The newly definitions reduced the size of some statistical geographic areas by separating suburban areas from outlying rural areas.<sup>124</sup> However, these same definitions also expanded the size of many larger metropolitan areas by incorporating smaller suburbs into the definitional boundaries.<sup>125</sup>

OMB specifically addressed the geographic areas issue upon releasing the census material in late 2000, stating that "OMB establishes and maintains these areas solely for statistical purposes."<sup>126</sup> Additionally, OMB stated that the geographic definitions "may or may not be suitable for use in program funding formulas,"<sup>127</sup> intending to warn both private and public sector agencies against using the information for anything other than statistical purposes.<sup>128</sup> As discussed in the previous section, the MSAs were designed for statistical comparison purposes, and their use to determine funding parameters for specific federal programs may be outside of the scope of their creation. Further, adopting the MSAs for funding purposes without

121. 42 C.F.R. § 412.64 (2004) (stating that CMS will calculate MMA payments using the geographic boundaries defined by the OMB); *see also* Santora, *supra* note 8 at B02.

122. *See* Santora, *supra* note 8 at B02.

123. *See* Fair Market Rents for the Housing Choice Voucher Program and Moderate Rehabilitation Single Room Occupancy Program Fiscal Year 2005, 69 Fed. Reg. 59,004, 59,005 (Sept. 24, 2004) (stating that the new MSAs contain "substantial changes," and a "substantially revised standard," for defining the MSAs); *see also* Plaintiff's Complaint at ¶24, *Bellevue Hospital Center v. Thompson*, No. 04 Civ. 08639 (S.D.N.Y. filed Nov. 1, 2004) (filing of complaint on behalf of 75 New York hospitals to protest CMS's adoption of the newly defined geographic funding areas); *see also* Santora, *supra* note 8, at B02.

124. *See* Plaintiff's Complaint at ¶26, *Bellevue* (No. 04 Civ. 08639) (noting that the contracted statistical areas resulted in more accurate wage comparisons because they excluded outlying rural areas and counties).

125. *See id.* (stating that the OMB definitions also expanded the size of 47 metropolitan areas to incorporate lower wage areas and distort the accuracy of wage comparisons).

126. Standards for Defining Metropolitan and Micropolitan Statistical Areas, 65 Fed. Reg. 82,228 (Dec. 27, 2000).

127. *Id.*

128. *Id.* OMB specifically stated that the areas used to define urban and rural statistical areas, "should not be used to develop or implement federal, state and local nonstatistical programs without full consideration of the effects of using these definitions for such purposes."



analyzing the underlying issues may cause the agency to overlook the real problems or address them incorrectly.

Following a review of the OMB's boundary changes in August 2003, CMS declined to adopt these changes, anticipating the drastic impact they could have on hospital funding.<sup>129</sup> CMS expressed the need to conduct further studies on the issue and consider alternative proposals to the new MSAs.<sup>130</sup> However, there is no record of CMS conducting formal studies or review of the new MSA boundaries.<sup>131</sup> CMS appeared to heed OMB's warnings until August 11, 2004, when CMS finalized a proposal to adopt the newly defined boundaries.<sup>132</sup> CMS's change resulted in an expansion of previous geographic areas used for large metropolitan cities that have been enlarged to include more outlying suburbs.<sup>133</sup> This is significant because the expanded geographic areas include labor markets that pay lower rates than the hospitals in a traditional urban area.<sup>134</sup> As a result, incorporating the lower cost areas dilutes the overall wage adjustment for the region.<sup>135</sup>

In reaction to CMS's adoption of the new boundaries,<sup>136</sup> a group of 76 hospitals in New York City and surrounding Northern New Jersey suburbs filed a lawsuit alleging that HHS had violated the Medicare Act.<sup>137</sup> The hospitals claim that HHS failed to properly adjust payment rates according

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129. See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates, 68 Fed. Reg. 45,346, 45,400 (Aug. 1, 2003) (to be codified at 42 C.F.R. pt. 412 & 413)(noting that the "new designations have extensively revised the construct of many of the existing Metropolitan areas" and could have serious implications for hospitals and counties around the nation).

130. See Plaintiff's Complaint at ¶32(b), *Bellevue Hospital Center v. Thompson*, No. 04 Civ. 08639 (S.D.N.Y. filed Nov. 1, 2004).

131. See *id.* at ¶25.

132. See 42 C.F.R. § 412.64 (2004). The regulation explicitly states that the metropolitan statistical areas will be "defined by the Office of Management and Budget." §412.64(b)(1)(ii)(A).

133. See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates, 68 Fed. Reg. 45,346, 45,400 (Aug. 1, 2003); see also Santora, *supra* note 8 at B02.

134. See Plaintiff's Complaint at ¶26, *Bellevue* (No. 04 Civ. 08639) (stating that the new boundaries used by CMS expanded the boundaries of 47 metropolitan areas to include areas with lower wage indexes); see also Santora, *supra* note 8 at B02.

135. See Plaintiff's Complaint at ¶26, *Bellevue* (No. 04 Civ. 08639).

136. See 42 C.F.R. § 412.64(b)(1)(ii)(A) (defining an "urban area" means a "Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget").

137. See Plaintiff's Complaint at ¶26, *Bellevue* (No. 04 Civ. 08639).

to the average wage level of the geographic area.<sup>138</sup> Central to the urban hospitals' argument is an OMB statement made after issuing the new urban area definitions, offering that federal agencies should conduct a full analysis of the impact of the new definitions before taking any steps to implement them.<sup>139</sup> The hospitals allege that CMS adopted these changes without any studies or analysis of their impact.<sup>140</sup>

The suit also argues that CMS agreed with criticisms of the current Medicare geographic-area definitions, and acknowledged the need to devise more accurate classifications for the amount of labor costs faced by hospitals in major urban and suburban areas.<sup>141</sup> However, CMS never took adequate steps to deal with the issues.<sup>142</sup> Instead, CMS adopted the new MSA definitions without conducting studies or due diligence,<sup>143</sup> "simply because they were the 'closest approximation' to the old MSAs."<sup>144</sup> As discussed in the following section, the actions by CMS to adopt the new MSAs were arbitrary and lack a rational basis.

#### IV. THE NEWLY DEFINED "MSA" AND THE PROJECTED IMPACT OF ITS ADOPTION

##### *A. The Impacts of Adopting New MSA Boundaries*

Congress established the Medicare Prospective Payment System ("PPS") in 1983 to help compensate hospitals for expenses related to inpatient services.<sup>145</sup> The size of the PPS payment is determined by the nationwide average cost of treating a typical patient.<sup>146</sup> Recognizing that using a single

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138. *Id.* at ¶36. *See also* 42 U.S.C. §1395ww(d)(3)(E) (requiring the Secretary of Health and Human Services to set payment rates for hospitals that account for the, "relative hospital wage level in the geographic area of the hospital compared to the national average wage level.").

139. *See* Standards for Defining Metropolitan and Micropolitan Statistical Areas, 65 Fed. Reg. 82,228 (Dec. 27, 2000).

140. *See* Plaintiff's Complaint at ¶25, *Bellevue* (No. 04 Civ. 08639).

141. *Id.* at ¶50.

142. *Id.* at ¶48 (stating that although CMS never performed an evaluation of the financial impact of the new MSA definitions).

143. *Id.*

144. *Id.* at ¶50.

145. *See* 42 U.S.C. § 1395ww(d) (reimbursing hospitals for operating costs incurred for inpatient services by paying a predetermined amount per discharged patient).

146. 42 U.S.C. § 1395ww(d)(2). The PPS rate "consists of two components: wage related costs and non-wage related costs." Plaintiff's Complaint at ¶8, *Bellevue* (No. 04 Civ. 08639).

national average adjustment payment would disproportionately hurt urban hospitals, Congress created a statutory adjustment to reflect the wage differences in different metropolitan areas.<sup>147</sup> The newly defined metropolitan areas adopted by CMS disproportionately skew the PPS adjustments by grouping outlying suburban areas into larger urban areas.<sup>148</sup> The suburban areas typically hire employees from a different labor pool and pay lower wages than the urban areas, resulting in a diluted wage index for the entire "metropolitan area," as defined by CMS.<sup>149</sup>

New York City hospitals appear to suffer the greatest financial impact from the newly defined urban areas.<sup>150</sup> Under the previous system, the New York City metropolitan area was defined as New York City, Westchester County, Putnam County, and Rockland County.<sup>151</sup> The new OMB definition of the area used for statistical purposes, and later adopted by the CMS for funding purposes, expands the area to include Bergen, Passaic, and Hudson Counties, all located in New Jersey.<sup>152</sup> The newly expanded area incorporates 21 new hospitals from the outlying counties who pay average wages ranging from 10-20% less than the average wages paid in New York City hospitals.<sup>153</sup> As a result, the wage index used to adjust PPS payments for the New York City area was reduced by over two percent, from 1.3596 to 1.3317.<sup>154</sup> The hospitals project that the inclusion of these 21 hospitals will result in an \$812 million reduction in annual reimbursements over the next 10 years.<sup>155</sup>

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147. 42 U.S.C. § 1395ww(d)(3)(E) (stating that the Secretary shall adjust the national average PPS payment figure according to the wage index and related costs of the geographic area that the hospital is in). The statute requires upward adjustment for hospitals in geographic areas with wages above the national average, and a reduction for hospitals in geographic areas below the national average. Plaintiff's Complaint at ¶10, *Bellevue* (No. 04 Civ. 08639).

148. Plaintiff's Complaint at ¶26, *Bellevue* (No. 04 Civ. 08639).

149. See *id.* at ¶27.

150. See Santora, *supra* note 8 at B02.

151. See Plaintiff's Complaint at ¶27, *Bellevue* (No. 04 Civ. 08639).

152. See *id.*; see also 42 C.F.R. § 412.64(b)(1)(ii)(A)(Oct. 1, 2004)(adopting the MSAs created by the OMB for use in the CMS's determination of PPS payments).

153. See Plaintiff's Complaint at ¶27, *Bellevue* (No. 04 Civ. 08639). The average hourly wage for New York City hospitals was \$35.05, whereas the average hourly wages for the Counties of Bergen, Passiac, and Hudson were \$31.50, \$28.75, and \$27.77, respectively. *Id.*

154. See *id.* at ¶28.

155. See *id.*; see also Santora, *supra* note 8 at B02 (citing an earlier estimation by the Greater New York Hospital Association that the changes would cost an estimated \$930 million over the next 10 years).

*B. CMS Arbitrarily and Capriciously Adopted the Changes*

The OMB explicitly states that MSAs “may or may not be suitable for use in program funding formulas.”<sup>156</sup> However, CMS adopted the newly defined MSAs “without conducting any study as to whether the new MSA boundaries were suitable or appropriate for determining wage-area differences.”<sup>157</sup> Comparison to other agencies highlights CMS’s capriciousness in adopting these standards.<sup>158</sup> On September 24, 2004, approximately one month after CMS adopted the new definitions, the Department of Housing and Urban Development (“HUD”) declined to adopt the new MSAs.<sup>159</sup> HUD’s stated reason for refusing the new MSA definitions was the “magnitude of changes caused by use of new OMB metropolitan area definitions and the inadequate time given to evaluate and respond to the proposed changes.”<sup>160</sup> HUD declined to use the updated MSAs even though they are required by statute to use the most “recent available data.”<sup>161</sup> HUD also noted that the large number of comments advising against adoption of the new MSAs prompted the need to perform further studies before adopting such drastic changes.<sup>162</sup>

The need for a review process was further indicated by the response OMB received after making the announcement of the new MSAs.<sup>163</sup> OMB received complaints from several different local, federal, and non-

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156. See Standards for Defining Metropolitan and Micropolitan Statistical Areas, 65 Fed. Reg. at 82,228.

157. See Plaintiff’s Complaint at ¶25, *Bellevue* (No. 04 Civ. 08639).

158. See *id.* at ¶22 (stating that HUD conducted further review of the proposed MSA changes and declined to adopt them due the magnitude of the resulting changes and insufficient time to perform an adequate financial evaluation).

159. See Fair Market Rents for the Housing Choice Voucher Program and Moderate Rehabilitation Single Room Occupancy Program Fiscal Year 2005, 69 Fed. Reg. at 59,004, 59,005; see also Plaintiff’s Complaint at ¶22, *Bellevue* (No. 04 Civ. 08639).

160. See Fair Market Rents for the Housing Choice Voucher Program and Moderate Rehabilitation Single Room Occupancy Program Fiscal Year 2005, 69 Fed. Reg. at 59,005; see also Plaintiff’s Complaint at ¶22, *Bellevue* (No. 04 Civ. 08639).

161. See Fair Market Rents for the Housing Choice Voucher Program and Moderate Rehabilitation Single Room Occupancy Program Fiscal Year 2005, 69 Fed. Reg. at 59,005. (explaining that although HUD has statutory requirements to use the most recent data, there are exceptions for the most current OMB MSA definitions).

162. See *id.* (discussing the large number of complaints received from individuals and local governments, and the need to further research the impact of the new MSAs before adopting such drastic changes).

163. See Standards for Defining Metropolitan and Micropolitan Statistical Areas 65 Fed. Reg. at 82,230 (stating that the OMB received 1,672 comment letters from different individuals, politicians, and other government groups expressing concerns about the new definitions).

governmental groups, including twenty-five members of Congress.<sup>164</sup> Among the comments received, the OMB noted that some warned specifically of possible adverse effects for health-related programs.<sup>165</sup> Complaining parties also requested that the OMB issue stronger statements about the intended uses of MSAs.<sup>166</sup>

Despite the concern expressed from public officials and local governments to the OMB, CMS decided to forego studies of the MSA changes and adopt the revisions.<sup>167</sup> Furthermore, like the OMB and HUD, CMS also received several comments urging consideration of studies before adopting the new MSA boundaries.<sup>168</sup> CMS also acknowledged that OMB specifically warned against use of the MSAs for federal funding purposes without first evaluating the impact.<sup>169</sup> However, CMS still decided to adopt the radically new MSA definitions without conducting a new study.<sup>170</sup> Rather than conduct a new study, CMS referenced research they conducted in 1994.<sup>171</sup>

CMS's decision to adopt the new MSAs without new or updated research on their effects contradicts CMS's own official statements.<sup>172</sup> CMS stated that MSAs "are not designed specifically to define labor market areas."<sup>173</sup> However, CMS defends using MSAs to define labor markets because "they [MSAs] do represent a useful proxy for this purpose."<sup>174</sup> Considering the

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164. *See id.*

165. *See id.*

166. *See id.*

167. *See* Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, 69 Fed. Reg. 48,916, 49,028 (Aug. 11, 2004).

168. *See id.* at 49,027 (noting that several comments urged CMS to use models that differed from the proposed MSAs).

169. *See id.*

170. *See* Plaintiff's Complaint at ¶25, *Bellevue Hospital Center v. Thompson*, No. 04 Civ. 08639 (S.D.N.Y. filed Nov. 1, 2004).

171. *See* Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, 69 Fed. Reg. at 49,027 (stating that in proposed rule 59 Fed. Reg. 27,724, CMS presented research on which standards to use for defining labor markets).

172. *See id.* at 49,027-28 (stating that comments regarding the effect of the new MSAs on large, urban hospitals "merit further study and consideration"); *see also* Plaintiff's Complaint at ¶32(b), *Bellevue* (No. 04 Civ. 08639) (claiming that although CMS stated they would investigate the claims of urban hospital's further, no studies were conducted prior to adopting the new definitions).

173. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, 69 Fed. Reg. at 49,027 (referring to both the adoption of MSAs for defining labor markets in 1994 and the continued use).

174. *Id.*

express warnings of the OMB and the magnitude of the projected impact on hospitals in New York City, there appears to be no rational justification for adopting the new MSAs without any sort of study or analysis.<sup>175</sup>

CMS's justifications for adopting the new MSAs without performing studies appear equally void of logic.<sup>176</sup> First, CMS argues that the comments received during the proposed rule period were inconsistent.<sup>177</sup> This argument is illogical on its face; CMS is essentially saying that because a debate exists, there is no need to investigate further.<sup>178</sup> CMS fails to mention that the hospitals supporting the adoption of the new MSAs are the same hospitals that stand to gain the most.<sup>179</sup> CMS further argues that studies of alternatives to the new MSAs are not warranted, because "hospitals that st[oo]d to benefit from the new definitions might experience lesser gains from the proposed revisions."<sup>180</sup> While this may be true, it does not address the possibility that adopting the new definitions without further studies could cause greater damage to urban hospitals than to the hospitals that benefit.

CMS also attempts to justify the adoption of the new MSA definitions by offering to phase the transition of the funding over a one-year period.<sup>181</sup> According to CMS, the one year transition "will alleviate the concerns of many hospitals, by limiting the reductions [] they might otherwise experience...."<sup>182</sup> A one year transition of blended wage differentials will certainly mitigate the impact on urban hospitals for that one year period, but it does not change the long term impact of adopting the new MSAs. The

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175. See Standards for Defining Metropolitan and Micropolitan Statistical Areas, 65 Fed. Reg. at 82,228 (stating the OMB's warning to federal agencies that studies should be performed before adopting the MSAs for funding purposes); see also Plaintiff's Complaint at ¶28, *Bellevue* (No. 04 Civ. 08639) (projecting the newly adopted MSAs to cost New York City hospitals approximately \$812 million over the next 10 years).

176. See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, 69 Fed. Reg. at 49,028; see also Plaintiff's Complaint at ¶32(c), *Bellevue* (No. 04 Civ. 08639).

177. See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, 69 Fed. Reg. at 49,028.

178. See Plaintiff's Complaint at ¶52, *Bellevue* (No. 04 Civ. 08639) (stating that CMS adopted the new MSA definitions without conducting further studies because there was no consensus among the hospitals).

179. See *id.* (arguing that due to the nature of the wage indexes, there will always be "winners" and "losers," and thus no consensus on CMS funding decisions).

180. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, 69 Fed. Reg. at 49,028.

181. See Plaintiff's Complaint at ¶32(c), *Bellevue* (No. 04 Civ. 08639).

182. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, 69 Fed. Reg. at 49,028.

only substantial effect of a waiting period is that hospitals receive time to eliminate staff, raise prices, or find other ways to eliminate operating expenses.

Finally, CMS attempts to justify the lack of studies by claiming that implementation of the new MSA definitions has been delayed for one year.<sup>183</sup> Again, this argument is factually correct,<sup>184</sup> but it represents no rational basis for implementing a drastic change without first conducting a study. The appearance is that of an agenda to increase funding to rural hospitals without concern for the projected adverse impact on hospitals in major urban areas.<sup>185</sup> Simply put, CMS provides no explanation for adopting the new MSAs without conducting research and in violation of the express warning from OMB.<sup>186</sup>

## CONCLUSION

The debate over allocation of federal funds between urban and rural areas has existed for several decades and reaches beyond the area of health care.<sup>187</sup> The important point for government agencies and lawmakers to realize is that the issues faced by both distinct groups change over time. The view that rural hospitals suffer relative to urban hospitals may have been true twenty years ago,<sup>188</sup> but is presently outdated.<sup>189</sup> As such, it is important to avoid arbitrarily accepting these definitions without first performing the necessary research and due diligence to determine the impact.<sup>190</sup>

Not to be overlooked in this debate over whether to aid rural hospitals at the expense of those in major cities is the political context. Many of the areas that benefited most from the adopted changes were hospitals in outlying suburban areas of New Jersey and Pennsylvania. Both of these states were so called "battle ground" states and were projected to be close

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183. See *id.*

184. See Plaintiff's Complaint at ¶¶ 24-25, *Bellevue* (No. 04 Civ. 08639) (discussing CMS's August 1, 2003, decision to decline adopting the new MSA definitions).

185. See *id.* at ¶45 (alleging that CMS has focused its efforts on preventing negative impacts on rural hospitals and provided relatively no protection to many urban hospitals).

186. See Standards for Defining Metropolitan and Micropolitan Statistical Areas, 65 Fed. Reg. at 82,228.

187. See Basset, *supra* note 1, at 276.

188. See *supra* notes 2-4 and accompanying text.

189. See *supra* Part II (discussing the problems facing urban health care systems).

190. See *supra* note 175 (citing the OMB's warning against using the MSA definitions without first conducting studies to gauge the impact).

decisions in the 2004 Presidential Election. The hospitals injured most by the changes were in New York City, an area solidly behind John Kerry, with no realistic chance of voting in favor of the incumbent President. Given the lack of a plausible explanation from CMS, the true reason for these dramatic changes could have been politically driven.